House Committee on Energy and Commerce

Health Subcommittee

"The Use of Imaging Services: Providing Appropriate Care for Medicare Beneficiaries"

Statement of

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on behalf of the National Coalition for Quality Diagnostic Imaging Services (NCQDIS)

July 18, 2006

Chairman Deal, Ranking Member Brown, distinguished Members of the Subcommittee, my name is Robert Baumgartner, and I am the Chief Executive Officer for Center for Diagnostic Imaging Inc. I am very pleased to be here today as a representative for the National Coalition of Quality Diagnostic Imaging Services (NCQDIS), of which am a member of their Board of Directors.

NCQDIS is a non-profit organization, representing 2,400 outpatient imaging clinics and independent diagnostic testing facilities (IDTFs) throughout the United States. As described by Executive Director Cherrill Farnsworth, "NCQDIS and its members are at the forefront of medical technology, providing physicians and patients with the most state-of-the-art innovations, techniques and procedures available in diagnostic imaging."[1]

[1] U.S. H.R. Comm. on Ways and Means, Health Subcomm., *Utilization of Medical Imaging*. 109th Cong. (February 10, 2005) (taken from prepared written testimony of Cherill Farnsworth, Executive Director, National Coalition for Quality Diagnostic Imaging Services (NCQDIS)).

I applaud the Subcommittee on Health for committing its time and resources to address today's important topic. As you know, it has been well-documented by the Centers for Medicare & Medicaid Services (CMS) and private payers alike that imaging utilization and spending have been growing at a rate faster than other health care expenditures. NCQDIS and its members believe that appropriate imaging utilization is an issue for both the public and private sectors, and you will learn about some of this coalition's related efforts today.

Our goal is appropriate utilization: the right procedure, at the right time, done right. NCQDIS has been actively engaged with CMS on this topic, recommending certain criteria that we believe CMS should consider in improving quality in imaging, reducing improper utilization, and better aligning federal standards with those in the commercial sector. But above all, NCQDIS firmly believes that the focus of this Committee should be on ensuring the highest value in the services provided to the nation's Medicare and Medicaid beneficiaries, and we believe that this can be done by providing clinically appropriate guidelines to all imaging providers that will have the net result of reducing over-utilization, and promoting the best possible care for beneficiaries. An across-the-board reduction in payments, as promulgated in the Deficit Reduction Act (DRA), without due consideration of the nuances of the imaging market and the resulting impact on beneficiaries will not improve quality or utilization and may, in fact, have the opposite effect.

My company, CDI, has been a leading provider of outpatient imaging services for 25 years. Our founder, Dr. Kenneth Heithoff, was one of the first physician pioneers to advocate for more cost-effective, convenient and appropriate imaging services – and he did so originally by opening one of the first outpatient imaging centers in the country in 1980. Since that time CDI has grown to now serve 14 communities in Minnesota, Wisconsin, Illinois, Indiana, Missouri, Kansas, Florida and Washington. We are pleased to have received this year the distinction of "Number One Freestanding Imaging Group" in the U.S. by the readers of *Medical Imaging* magazine, a leading, national industry publication.

The principles of CDI are straightforward and unwavering: to deliver accurate, efficient diagnostic imaging services in an accessible and compassionate manner. To do so, we partner with specialized, board-certified, local radiologists in conjunction with community health systems, hospitals and physicians. For example, in St. Louis we have collaborated with St. Luke's Hospital as well as with the St. Louis Cancer & Breast Institute. In Minnesota, we are working with the Mayo Clinic in a small city and with a rural county-owned hospital and surrounding physicians, as well as providing convenient access for patients in the three main population centers of the state.

For CDI and other NCQDIS members, our commitment to consistent standards and appropriate utilization has always been critical to our success. As an independent imaging provider, we cannot create demand for our services. Let me underscore this point: the volume of procedures referred to NCQDIS members cannot be initiated or self-promoted,

and we therefore represent an independent clinical viewpoint. We, like other IDTFs, must prove to referring physicians and their patients that we are worthy of their continued referrals. At CDI, we prove ourselves by maintaining a national, robust peer-review program, ongoing patient satisfaction surveys, sophisticated quality assurance initiatives, use of advanced imaging equipment, ACR accreditation of our MRI and CT scanners, electronic portal access to images and reports for referring physicians, and an insistence on radiologist specialization. Other NCQDIS members offer similar listings of service and quality indicators.

I. Industry Overview: Trends and Types of Providers in Outpatient Imaging

Before discussing specific utilization and quality topics, it is important to recognize the macro healthcare environment. Two significant national trends have and will continue to cause a natural and positive increase in diagnostic imaging utilization in the United States.

First, the use of imaging tests and procedures increases as we get older, and the 'Baby Boom' generation continues to age. By 2010, it is estimated that this generation will constitute 79 million people in the U.S.[2] Appropriate use of imaging procedures will play a crucial role in the early detection and treatment planning for the medical needs of these

[2] Kimberly Scott, *2006 Diagnostic Imaging Industry Strategic Outlook: Market Trends & Analysis* (Wash. G-2 Reports 2005).

beneficiaries, so that overall costs on repeat exams, incorrect/non-concise and/or late-stage diagnoses and complications are avoided.

Second, demand for imaging services overall is also increasing due to advances in technology and applications. For example, new and less-invasive – yet efficacious and cost-effective – image-guided procedures are being developed and used as alternatives to costly and more invasive procedures like surgeries. Advanced applications, new contrast agents, refined scanners and new protocols are being brought to market and focused on specific medical specialties, benefiting patients with diseases or injuries such as cancer, neurological and cardiovascular diseases and musculoskeletal injuries (e.g. hips, knees and spines). As former Senator and Medicare Payment Advisory Commission (MedPAC) Commissioner Dave Durenberger recently noted, "Innovation is a value in healthcare and needs to be encouraged by policy."[3]

The Outpatient Diagnostic Imaging Environment

To better understand the issue of imaging utilization, it is important to understand exactly who provides imaging services. Imaging services are delivered in a variety of ways to Medicare beneficiaries.

First, an imaging procedure is performed only after a physician has evaluated a patient's condition and produced an order (similar to a prescription) for a specific imaging

[3] David Durenberger, Presentation, *Defining the Medical Arms Race Syndrome* (National Institute of Health Policy, July 13, 2006) (Minneapolis, Minn.).

procedure that he or she feels is necessary to aid in the patient's diagnosis. The procedure has two components – the exam itself, and the radiologist's interpretation.

The imaging exam (the experience of the patient coming to the clinic and having the actual procedure done) is typically referred to as the "technical" component. Types of diagnostic imaging examinations include:

- MRI (Magnetic Resonance Imaging);
- CT or CAT (Computed Tomography);
- PET or PET.CT (Positron Emission Tomography);
- Ultrasound;
- X-ray;
- DEXA/Bone Densitometry;
- Mammography; and
- Nuclear Imaging.

After the "technical" imaging procedure is complete, the images are then sent for interpretation to a radiologist, who studies the images and delivers a written report back to the referring physician with the results of the imaging examination. Radiologists are physicians who must complete an additional 4 to 6 years of education and internships after completing their medical degrees before being licensed as a general radiologist. Fellowship-trained radiologists are further trained in specific areas of the anatomy or on specific imaging equipment, and require another two years of fellowship training.

Imaging equipment is owned, and technical services are provided by, a variety of sources.

The major provider segments are:

- Hospitals (both inpatient and outpatient);
- Independent Diagnostic Testing Facilities (IDTFs);
- Radiologist Offices; and
- Non-radiologist Physician Offices.

Hospitals typically provide both inpatient and outpatient imaging services at the hospital, and may also own imaging facilities geographically distant from the hospital campus to provide better community access. Hospitals are regulated facilities that provide on-site radiologists for required procedures and to supervise staff and assuring compliance with accreditation requirements such as JCAHO (Joint Commission on Accreditation of Healthcare Organizations). Hospitals provide imaging services for trauma patients, inpatient care and outpatients. Outpatient referrals come from on-staff hospital physicians, independent hospital physicians and community physicians.

Independent diagnostic testing facilities (IDTFs), which NCQDIS represents, are imaging facilities that exist outside the hospital setting and are not physically located in physician offices. They may be owned by hospitals, radiologists or investors. IDTFs have more rigorous federal regulations than other imaging providers; they must provide on-site radiologists for certain procedures, have qualified and certified technologists to operate the imaging equipment, and typically have their equipment certified by the American College of Radiology (ACR). Nationwide, there are approximately 5,000 IDTFs. As noted earlier, independent facilities, IDTFs cannot refer to themselves or create demand

for their services. They provide service only after a physician has ordered an imaging procedure for his or her patient. IDTFs provide quick, convenient and high-quality access to imaging procedures that may not be available through the local hospital and generally provide same-day service for patients.

Radiologists may or may not own imaging facilities. Oftentimes radiology groups practice inside the hospital to provide interpretation services and consultation to hospital physicians. In certain instances, the radiologist may own the imaging equipment in the hospital or at hospital-based facilities. A radiologist may also own an IDTF in partnership with hospitals and investors. Radiologists also provide interpretation services to IDTFs and physician-owned imaging equipment. By law, radiologists are deemed not able to refer patients, and are considered independent imaging providers since they do not examine patients and order imaging services.

As a result of the in-office ancillary exceptions provided by Stark I and Stark II, non-radiologist physicians are able to install imaging equipment inside their offices or collaborate with other physicians to own or lease imaging equipment. In physician-owned imaging centers the primary source of referrals is from the physicians who own the equipment. Physician practices are not subject to the same requirements as IDTFs in terms of having a radiologist on site, nor are they required to have certified technologists as required for IDTFs.

NCQDIS believes this information to be critical in discussing consistency in standards, in understanding where and how over-utilization is occurring, and in discussing reimbursement.

II. Consistent Standards for All Imaging Providers: Assuring Value for Medicare and Medicaid Beneficiaries

NCQDIS and its members believe that the first step in consistent standards for all providers is the uniform application of IDTF regulations to all types of imaging providers.

Effective July 1, 1998, Medicare regulations provided for the implementation of the new provider designation of independent diagnostic testing facility ("IDTF")[4]. The IDTFs replaced the previous provider category of independent physiological laboratory (IPL). IDTFs are to be independent of a physician's office or a hospital, although either can apply to be an IDTF and therefore are not barred from meeting higher standards. The Medicare carriers are charged with determining that all IDTF applicants meet the IDTF standards as required by CMS prior to enrollment and granting an IDTF applicant a Medicare billing number.

Arguably, the purpose of creating the IDTF classification was to ensure that diagnostic testing performed outside the traditional inpatient hospital or radiologist office setting

[4] 42 C.F.R. § 410.33.

met certain quality and safety standards, which also help to assure appropriate utilization. However, many believe that the Stark "in-office ancillary exception" has fostered the proliferation of imaging in physician offices, raising the question as to whether the goal of quality and safety has been achieved beyond the enrolled IDTFs. In fact, those entities that enroll and bill as an IDTF are disadvantaged from a competitive standpoint due to the regulatory requirements placed on the IDTF but not the other types of outpatient imaging entities. These include:

- **Supervising Physician Requirement**

  Currently Medicare Carriers are taking the position that, with limited exception for certain specialties, each supervising physician in an IDTF needs to be a radiologist. Some carriers have extended that definition to require board-certified radiologists. The goal of the regulations is clearly to ensure that the "supervising physician" oversee the quality of the testing equipment and the technologists who will be performing the tests utilizing such equipment. However, the Carriers place no such supervising physician requirements upon non-IDTF imaging providers such as outpatient hospital facilities or physician office imaging facilities;

- **Non-Physician (Technologist) Requirements in the IDTF Setting**

  The Medicare Carriers are given the authority to determine whether an imaging center technologist is qualified to conduct the diagnostic tests the IDTF is performing. Some Carriers have taken the position that such training and proficiency must be to the level of specific accreditation in the imaging modality

in which the technologist is operating. This goes above and beyond state licensing or national credentialing of American Registry of Radiologic Technologists ("ARRT"). Thus, the Medicare beneficiaries who are receiving services in the IDTF setting are being treated by highly credentialed technologists under the supervision of radiologists. In other outpatient settings the technologists are not required to meet these same standards. Again, if having a technologist, who is not only certified but certified in a specific imaging modality, is important to have in place in an IDTF, then it should be important in all settings where Medicare beneficiaries are receiving outpatient imaging;

- **Written Orders are Mandated at IDTFs**

  While not clarified for physician offices, IDTFs are specifically required to proceed with care only with a written order in place. This small step is useful in assuring appropriate utilization. Certainly, if CMS is adhering to the quality components of patient safety and effectiveness, such a requirement is at least as important in a physician office setting or hospital.

To summarize, the following chart is a comparison of IDTF requirements to other imaging settings:

CMS Criteria	Type of Imaging Provider		
	IDTF	Physician	Hospital
Physician Supervision	Required	Required	Not Required
Supervising Physician Qualifications determined by Carrier (**Radiologist, and for many Carriers, Board-Certified**)	Required	Not Required	Not Required
Non-Physician Personnel (Technologist) Qualifications	Required	Not Required	Not Required
Written Orders	Required	Not Clarified	Not Clarified

Let me underscore: NCQDIS and its members are not seeking an advantage in either regulatory oversight or reimbursement, but rather, IDTFs are simply seeking a level playing field on which to operate. Advances in diagnostic imaging have led to tremendous strides in patient care: from reducing the need for invasive surgical procedures to early detection of life-threatening diseases. However, imaging equipment and facilities operated by providers not specifically trained to provide complex diagnostic imaging services can be sub-optimal with regard to equipment quality, technologists operating the equipment, the quality of images produced, and ultimately interpretation of these diagnostic images. In addition, images taken by technologists who do not meet IDTF qualification standards may produce lesser-quality images that even the best-trained physician will have trouble interpreting.

Recommendation:

NCQDIS recommends that the existing IDTF regulations be used as a model to address all outpatient imaging operations, including those that fall under the Stark "in-office ancillary exception," hospital outpatient imaging facilities, and outpatient imaging facilities that are not enrolled in the Medicare program under the IDTF classification. This will guarantee progress in assuring appropriate utilization and offer more value for the beneficiary, as consistent standards will discourage non-qualified imaging facilities and reduce repeat examinations and diagnostically poor images caused by quality issues with either imaging equipment or staff.

III. Identifying, Measuring and Reporting Quality – Here and Now

NCQDIS has and will continue to advocate for Medicare's IDTF standards, as well as for additional community standards for the patients we serve. Several of our members have initiated efforts with their regional payers and purchaser-employers to identify community standards and best practices for imaging, and to measure and report their impact on utilization.

Identifying Quality Indicators

For example, CDI has been directly involved with an effort to identify best practices based on the components of quality as originally identified in *Crossing the Quality*

Chasm, the landmark Institute of Medicine (IOM) series of reports.[5] We have found our mid-sized employers and collectively-bargained (Taft Hartley) Trusts are especially appreciative of this characterization because it is one that they can use with their employees/membership to help promote more knowledgeable consumers of value services. Below are several categories as an illustration that the goal of consistent standards for imaging providers is not a years-long process, but rather an attainable, short-term goal.

[5] Institute of Medicine, *Crossing the Quality Chasm: A New Health System for the Twenty-first Century* (Washington: National Academy Press 2001).

Indicators for Purchasing Value in Imaging

Categories are those identified by the IOM in *Crossing the Quality Chasm* to assist consumers in making value-based decisions about imaging providers.

Safety:

- MRI and CT equipment that have been accredited by a national accrediting body
- Registered Technologists
- Safety and Adverse Event Reports
- Active Peer Review Program with full participation of all radiologists
- Adequate and accessible Patient Education to assure the patient understands the procedure being undertaken and the risks of it.

Effectiveness

- Fellowship trained sub-specialists
- *Registered Technologists
- Online report access for treating physicians
- *Accredited MRIs and CTs
- Internal and Referring Physician Education - development and promotion of best practices.

Patient-Centered

- Access/Locations
- *Fellowship trained sub-specialists
- *Registered Technologists
- Patient Satisfaction data (tracked over time)
- *Patient Safety Records
- *Patient Education – customized to appropriate audience
- Cost competitive with providers maintaining similar standards
- Prohibition and/or reporting of Self-referral/ownership/leasing for any imaging services over $100

Timely

- Turn Around Time on Reports (average time from when patient comes in or referred to facility to when report arrives at treating physician)
- *Online Report Access for treating physicians (this might be a sub-head of previous item)
- *Patient Satisfaction data (i.e., patient's view of if service was timely)

Efficiency

- State-of-the-art Radiology Information System
- High-field equipment
- *Online Report Access
- *Access and Location, including evening and Saturday hours

Equity

- *Cost competitive with providers maintaining similar standards
- *Prohibition on Self-referral for any imaging services over $100
- *Reasonable Access/locations

Indicates item is used in more than one category of quality

Measuring and Reporting Indicators of Quality

Another project CDI has contributed to is a program to assist employees in choosing health care providers based on value, which is defined through the formula of:

$$\frac{\text{Service, Access, Convenience, Safety, and Quality Outcomes}}{\text{Cost}}$$

This measurement-for-public-reporting effort requires that imaging providers be measured based on three weighted-value categories. With this model, the score for professional services is weighted at 40%, a weight of 30% is given to each imaging facility, and another 30% designated for service and consumer satisfaction. In a June 30, 2006, communication to CMS Administrator McClellan, NCQDIS shared the specific measures included in each of these weighted categories and would be pleased to share the same with any Member of this Subcommittee. Currently, a white paper is in development which will link each of these indicators to peer-reviewed literature regarding specific best practices in imaging, or to another type of community standard, such as the CAHPS® Clinician and Group Survey.[6]

Other Marketplace Activities Related to Appropriate Utilization

Private payers have become not only aware of the potential for over-utilization of imaging services, they are taking action. Many private payers and purchasers have started to impose minimum quality standards for imaging facilities and equipment, and/or have

[6] Agency for Healthcare Research and Quality, *Consumer Assessment of Healthcare Providers and Systems (CAHPS), CAHPS Clinician & Group Survey: Key Issues in Field Tests,* http://www.cahps.ahrq.gov/default.asp; path Work-In-Progress (accessed July 14, 2006).

hired third-party utilization review companies, often referred to as radiology benefit managers (RBMs).

As HealthHelp CEO Cherrill Farnsworth has explained:

> *"The second generation RBMs are encouraging and facilitating quality and safety. Measures such as tools for ordering the most appropriate tests and consistent quality standards for all imaging providers are saving 20-25% of total imaging costs. Cuts to reimbursement have been shown to save little or nothing. It is time that all payers, including CMS, reward quality and safety – and in the process, control over-utilization and costs. NCQDIS is happy to demonstrate this through actual case studies from the private sector."*

NCQDIS has spent the last year monitoring and collecting publicly available information from commercial payers and radiology benefits management companies (RBMs). We produced a tracking chart which we shared with CMS Administrator McClellan earlier, and which is appended to my testimony here today. Taken as a whole, the information on this chart indicates a sophisticated understanding by the majority of private payers that capital intensive imaging services must be managed in a more comprehensive manner than simply slashing reimbursement, and to encourage appropriate utilization.

In addition, many states have adopted more stringent Certificate of Need (CON) laws to review the need for higher-end equipment (such as MRI, CT and PET/CT) in the

community before the equipment may be ordered. One state, Maryland, has passed a law that does not permit non-radiologist physicians to refer to imaging equipment or facilities in which they have a financial interest. Other states have made it illegal for physicians to lease time on imaging equipment which is not located in their facility and then bill for those procedures, essentially receiving a profit for each scan that they order.

Recommendation:

NCQDIS and its members not only support but strongly encourage private and public efforts to develop and utilize consistent standards for all imaging providers. In addition, NCQDIS supports efforts to restrict leasing of imaging time on equipment not located in the physician office. NCQDIS believes both of these efforts will help reduce imaging over-utilization by ensuring that beneficiaries receive a consistent standard of care regardless of provider, and that tests performed are medically appropriate and accurate.

IV. Parity in Reimbursement is Critical to Achieving Value in Imaging Services

In the current absence of consistent standards of quality for all imaging providers, cutting reimbursement seems the natural alternative to curbing over-utilization. However cutting reimbursement alone will not yield the desired effect, as value in healthcare cannot be measured by price.

Additionally, rate-cutting alone will likely have the unintended impact of encouraging some providers who are able to control volume to increase referrals to "make up the difference" in lost revenue, reducing any potential savings to CMS or its beneficiaries. Worse, rate-cutting could lead to a lack of reinvestment in advanced imaging technologies, and thus extended use of older or minimally maintained equipment that produces poorer scans. The result could be missed or delayed diagnoses for beneficiaries.

To be clear, NCQDIS and its members support parity in reimbursement for all imaging providers when consistent standards are met, but believe this parity must be determined carefully and in context of the different types of imaging providers and their business/cost structures, and of the reasoning behind current CMS reimbursement categories.

Medicare uses two reimbursement categories today for imaging services: HOPPS and MPFS. Hospitals are paid for outpatient services provided to Medicare beneficiaries through a methodology called Hospital Prospective Payment System (HOPPS). The HOPPS payment methodology was determined using the following process: Hospitals allocate costs for capital equipment, supplies, staff and other expenses into cost centers that they then submit in aggregate (with charge data) to CMS on an annual basis. CMS calculates a cost-to-charge ratio (CCR) for each department and for the hospital as a whole. HOPPS groups 'clinically similar' services together into Ambulatory Payment Classifications (APCs), whose costs are determined by multiplying each charge on every

claim for a service in that APC by the hospital-specific CCR. The resulting HOPPS rate, in aggregate, is meant to reimburse the hospital for 82% of their costs.

Non-hospital outpatient imaging, independent diagnostic treatment facilities (IDTF) and physician offices are paid under a methodology called the Medicare Physician Fee Schedule (MPFS). MPFS bases payment for each imaging service on the costs associated with providing that service, including clinical staff, disposable supplies, capital equipment and administrative overhead. For each service provided, the MPFS assigns a payment rate based upon the actual costs of the services.

Unlike the MPFS, under which IDTFs are paid, HOPPS rate does not represent the true cost of providing imaging. The result of the methodology behind HOPPS is that neither the hospital, nor CMS, is able to identify the costs of providing individual imaging services within a particular hospital, especially over time. On the other hand, MPFS assigns a payment rate based upon the actual costs of each service.

It is also worth noting that hospitals receive additional payments from federal, state and local governments that are not available to non-hospital outpatient imaging providers. These additional payments are hospital-specific and are not figured into the national HOPPS payment rates. They include Disproportionate Share Hospital (DSH) payments for inpatient care (meant to offset the monetary losses hospitals incur when providing care to indigent patients), credit for bad debt, and, in some non-profit instances, tax-exempt bonding for capital expenditures and property taxes.

Last, hospitals provide a wide mix of services that subsidize one set of unprofitable services with others that are profitable. IDTFs instead concentrate on cost and quality of imaging services only.[7]

Recommendation

The disparity between HOPPS payment methodology and actual cost of providing individual services for IDTFs will lead to less competition in the imaging industry. Without a payment system that allows IDTFs to recoup actual costs of providing imaging services, IDTFs will not be able to meet consistent standards of quality nor improve services.

As mentioned previously, an IDTF cannot independently create demand for its services, and therefore relies upon providing quality services to attract the necessary demand.[8] It is therefore the position of NCQDIS that the discussion around quality and utilization is wholly ineffective and possibly counterproductive to have without including discussion on reimbursement. NCQDIS asks for the Members of this Subcommittee to consider the provision in H.R. 5704 that requires this comprehensive look at imaging reimbursement policy and we ask your support for it.

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[7] "Numerous studies show that when physicians or teams treat a high volume of patients who have a particular disease or condition, they create better outcomes and lower costs." Michael E. Porter, Elizabeth Olmsted Teisberg, *Redefining Competition in Health Care,* Harv. Bus. Rev. vol. 82(6), 64-76 (June 2004).

[8] "In healthy competition, relentless improvement in processes and methods drive down costs. Product and service quality rise steadily." Michael E. Porter, Elizabeth Olmsted Teisberg, *Redefining Competition in Health Care,* Harv. Bus. Rev. vol. 82(6), 64-76 (June 2004).

V. CONCLUSION

Medical advances are one of our society's great achievements, and the frail and elderly who depend on Medicare and Medicaid should be afforded the same access to this lifesaving and life-enhancing technology as those in the private sector. From the utilization perspective, rate cuts alone will not curb utilization. Congress and CMS have the tools to ensure this equality, and by promoting policies that move beyond short-sighted reimbursement-only methodologies to the more nuanced quality and value-based metrics such as those being used in the private sector, true parity for all imaging providers can be achieved, benefiting beneficiaries and taxpayers alike.

NCQDIS sincerely appreciates this opportunity, and we look forward to working with you and your colleagues, and the Administration, in the days ahead to address this important public need.

Appendix:

Private Payer / Radiology Benefits Management Activity
Related to Standards in Diagnostic Imaging

	CareCore National (For New Site or Modality Applications)	CareCore National (Standards for Continued Participation) *These standards will become effective 7/1/07	Anthem (Connecticut and Colorado)	Highmark (Pennsylvania)	HealthHelp RadSite® On-line assessment of an imaging provider's or physician practice's equipment, policies and personnel	BCBS IL - AIM MA, PA & DE
CT	• ACR • Software ≤ 4 yrs old • Min. 4 slices/rotation • Min. 16 slices/rotation for CTA of lower extremities • Min. 64 slices/rotation for Coronary CTA	• ACR • Min. 4 detectors ≤ 6 yrs old. • Software updated within 3 yrs. • Min. 8 detectors for virtual endoscopy • Min. 16 detectors for CT angiography • Min. 64 detectors for CCTA	• ACR (Within 1 yr.) • QC Program • Multi-modality (3) • MRA capability • No extremity scanners • Field strength of 0.5T or greater	• QC Program • Multi-modality (5) • Radiation Safety Program Staffing: • 10 day TAT • Min. 40 hrs/wk on business days, including one evening/wk until 8 PM and 2 sat/month for a min of 4 hrs/day • Highmark credentialed radiologist with current ACLS certification • Licensed or certified tech	**Assessed for:** detector rows 1,2,4,8,16,32; Performance capabilities; Table capacity in lbs; intervention; gating; fusion imaging; CT cardiac imaging; CT angiography; fluoroscopy; year of manufacture; year of last upgrade; Typical annual volume of studies performed on this device; maximum number of work days of delay in scheduling patients; type of accreditation; active or expired; date of last physicist report deeming device satisfactory; average repeat rate for x-ray device as a percentage of exams performed; alignment light accuracy; slice thickness; high contrast resolution; low contrast resolution; image uniformity; noise; artifact evaluation; CT number accuracy and linearity; gantry-table alignment; gantry tilt; localization image from a SPR; accuracy of table incrementation; computed tomography dosimetry index; patient radiation dose for representative exams; scattered radiation measurement. **Staffing:** Medical Director - specialty, training, accreditation and certification; Are imaging studies interpreted by licensed and board certified radiologist?; Imaging Manager; Imaging device operators; Radiation Safety Officer; Policy and Procedure: Same as MRI	Various pre-authorization required
MRI	• ACR & DICOM compatible • Software ≤ 3 yrs old • 0.30T- 0.6T and 1T devices manufactured prior to Dec. 31, 2001 limited to brain, spine, knees, and extremities. • If devices above have gradient strengths of at least 20mT/meter and slew rates of at least 45T/meter/sec, can apply to perform additional studies by submitting images to show current capacity. • 0.7T require ACR • 1.5T or > device manufactured after Jan. 1, 2002 must provide service records indicating maintenance of hardware at original standards and major software upgrades ≤ 3 yrs old. • Devices used for cardiac work must have EKG gating and at least 8 channel parallel processing. • Devices used for breast MRI must be ≥ 1T and have bilateral capabilities. • Devices 1T or > manufactured after Jan. 1, 2002 permitted to perform all exams.	• ACR • Hardware ≤ 6 yrs old. • Software ≤ 3 yrs. • MRA on 1.5T or greater	• ACR or ICANL by Nov. 1, 2007 (Within 2 yrs) • High performance full ring • QC Program Staffing: • Board certified in diagnostic radiology or nuclear medicine. • Certified techs in Nuclear Medicine through ARRT or NMTCB • 10 day TAT	• ACR within 1 yr • QC Program • Multi-modality (5) • MRA capability Staffing: • 10 day TAT • Min. 40 hrs/wk on business days, including one evening/wk until 8 PM and 2 sat/month for a min of 4 hrs/day • Highmark-credentialed radiologist with current ACLS certification • Licensed or certified tech	**Assessed for:** equipment type, year of manufacture; year of last upgrade; typical annual volume of studies performed, accreditation, date of last physicist report, average repeat rate, center of frequency, table positioning, setup and scanning, geometric accuracy, high-contrast resolution, low-contrast resolution, artifact analysis, film quality control, visual checklist, magnetic field homogeneity, slice position accuracy, slice thickness accuracy, radiofrequency coil checks, inter-slice radiofrequency interference. **Staffing:** Same as CT **Policy and Procedure Assessment:** Interpreted on site; JCAHO accreditation; site visit inspection; expiration date of facility's current state x-radiation license; pediatric parameters; technique charts; collimation; referring physicians and family members' ownership or leasing arrangements with center; written report; physician present for contrast dosimetry monitoring devices.	Various pre-authorization required

	CareCore National (For New Site or Modality Applications)	CareCore National (Standards for Continued Participation. These standards will become effective 7/1/07)	Anthem (Connecticut and Colorado)	Highmark (Pennsylvania)	HealthHelp (RadStaff Online assessment of an imaging provider's or physician practice's equipment, policies and personnel)	BCBS IL / AM MA PA & DE
PET	●ACR or ICANL ●Sodium Iodide detectors unacceptable regardless of configuration ●Must utilize a PET/CT machine ●PET/CT equipment older than 5 yrs must submit yearly reports that equipment is functioning per manufacturer's specifications	●ACR PET-only devices: ●Hardware ≤ 6 yrs. old ●Software ≤ 2 yrs. old ●Fusion software purchased/upgraded in last 2 yrs. PET/CT: ●No > 6 yrs. Old ●Software ≤ 2 yrs. Old	●ACR or ICANL by Nov. 1, 2007 (Within 2 yrs) ●High performance full ring ●QC Program Staffing: ●Board certified in diagnostic radiology or nuclear medicine ●Certified techs in Nuclear Medicine through ARRT or NMTCB ●10 day TAT	●QC Program ●High performance full ring Staffing: ●10 day TAT ●Performed by hospitals ●Techs certified in Nuclear Medicine through ARRT, CNMT, or NMTCB, or licensed by state.	Assessed For: Equipment type, gamma camera; performance capabilities; PET on general camera, SPECT; Fed pass; conventional, cardiac stress test, cardiac, year of manufacture, year of last upgrade, typical annual volume of studies performed; maximum number of work days of delay in scheduling patients; accreditation earned, accreditation expiration date, date of last physicist report deeming this device satisfactory; average repeat rate, sensitivity, energy resolution, count rate parameters, multiple window spatial registration, system safety interlocks; spatial resolution, intrinsic uniformity, dose calibrations, SPECT tomographic uniformity contrast and spatial resolution, SPECT center-of-rotation for multi-detector registration calibration, SPECT high count floods for uniformity correction Staffing: Same as CT Policy and Procedure Assessment: Same as CT	Various pre-authorization required
NUC MED	●All SPECT capable with at least 2 detectors ●ACR or ICANL ●Cardiac Nuclear Imaging exclusive centers: single detector systems acceptable. ●Centers performing Cardiac and generalized SPECT studies: multi head systems required. ●Jaszczak Phantom acquisition every 6 months ●SPECT mandatory ●Collimator Requirements: LEHR Low Energy (for High Resolution), Med Energy (for Indium & Gallium), High Energy (for centers performing I131 whole body studies) ●Quality Assurance Requirements: Auto. Integral & Field Uniformity (computed) < 5%SPECT: COS & Floods (computed) < 1-2 pixels ●Cardiac Nuclear Imaging Requirements: Quantitative Analysis package, Gating, EF Calculated, Motion correction, back filter projection reconstruction, or linx spread function software	●ACR or ICANL ●Devices ≤ 6 yrs. old ●All SPECT capable w/ at least 2 detector heads ●Nuclear cardiology software ≤ 3 yrs. old	●ACR or ICANL by Nov. 1, 2007 (Within 1 yr.) ●Imaging systems with capability of assessing myocardial perfusion and contractile function ●QC Program ●Inspection Record Echocardiography: ●Color Flow Doppler ●ICAEL by Nov. 1, 2007 (Within 2 yrs) Staffing: ●All least one board certified physician in diagnostic radiology, nuclear medicine, or is CBNC certified ●Certified tech through ARRT, CNMT, or NMTCB or licensed by state. ●Cardiac stress tests performed under ACLS or ARLS certified physician ●10 day TAT Echocardiography: ●Board certified in diagnostic radiology or cardiology	●ACR or ICANL within 2 yrs ●QC Program ●Imaging systems with capability of assessing myocardial perfusion and contractile function. ●Radioactive Materials License ●Inspection Record Echocardiography: ●Color Flow Doppler capability ●ICAEL within 2 yrs Staffing: ●10 day TAT ●Must employ at least one physician who is Highmark credentialed in diagnostic radiology, nuclear medicine or CBNC ●Cardiac stress tests performed under ACLS certified physician. ●Certified tech through ARRT, CNMT, or NMTCB, or licensed by state. Echocardiography: ●Credentialed by Highmark and/or Keystone Health Plan West in diagnostic radiology or cardiology	Assessed For: Equipment type, year of manufacture, year of last upgrade, typical annual volume of studies performed; maximum number of work days of delay in scheduling patients; accreditation earned, accreditation expiration date, date of last physicist report deeming this device satisfactory; average repeat rate as a percentage of total number of images produced, sensitivity, energy resolution, count rate parameters, multiple window spatial registration, system safety interlocks; spatial resolution, intrinsic uniformity, dose calibrations; SPECT tomographic uniformity, contrast, and spatial resolution; SPECT center-of-rotation for multi-detector registration calibration; SPECT high count floods for uniformity correction. Staffing: Same as CT Policy and Procedure Assessment: Same as CT	Various pre-authorization required

	CareCore National (Fee Fee Site or Modality Application)	CareCore National (Standards for Continued Participation) *These standards will become effective 7/1/07	Anthem (Connecticut and Colorado)	Highmark (Pennsylvania)	HealthHelp (HeartSuite On-line assessment of an imaging provider's or physician practice's equipment, policies and personnel	BCBS IL - AIM MI, PA & DE
Ultrasound	● ACR or AIUM ● Transducers to be available for exams offered by practice: ○ 4MHz Abdomen, Renal, Pelvic, OB Aorta ○ Curved 7.0MHz Pediatric abdomen, renal & pelvis ○ Linear 7.0MHZ Vascular ○ Linear 12MHz Breast, thyroid, testicular ○ 8.0MHz endovaginal ○ 9.0MHz endorectal ● Units < 7 yrs. Old ● If equip. is > 7 yrs old, must conform to all manufacturer specifications & have most current updated software. Also must pass ACR or AIUM standards.	● Devices ≤ 5 yrs. old ● Color Doppler capabilities ● Recording to film or electronic media (no paper)	● QC Program PV: ● Color Flow Doppler ● ICAVL or ACR by Nov. 1, 2007 (Within 2 yrs) OBGYN: ● AIUM or ACR by Nov. 1, 2006 (Within 1 yr) Urological: ● ARDMS or ARRT certified sonographers to perform certain ultrasounds of the abdomen, pelvis, and genitalia ● Uncertified sonographer will only meet criteria for prostate ultrasounds. Staffing: ● 10 day TAT ● PV: Board certified in diagnostic radiology, vascular surgery, cardiology or neurology. Sonographer certified by ARDMS or ARRT ● OBGYN: Board certified radiologists, obstetricians, and gynecologists ● Urological: Board certified radiologists and urologists, contrast enhanced procedures performed under ACLS certified physician	● QC Program PV: ● Sonographer certified by ARDMS or ARRT ● Color Flow Doppler capability OBGYN: ● AIUM or ACR within 1 yr Urological: ● ARDMS or ARRT certified sonographers to perform certain ultrasounds of the abdomen, pelvis, and genitalia ● Uncertified sonographer will only meet criteria for prostate ultrasounds. Staffing: ● 10 day TAT ● PV: Physicians credentialed by Highmark and/or Keystone Health Plan West in diagnostic radiology, vascular surgery, cardiology or neurology. ● OBGYN: Highmark and/or Keystone Health Plan West credentialed radiologist, obstetricians, and gynecologists. ● Urological: Radiologists and urologists credentialed by Highmark and/or Keystone Health Plan West, contrast enhanced procedures performed under ACLS certified physician.		Not Listed
Bone Density	● DEXA capable of lumbar spine, hip, and forearm studies ● Current participating providers using pencil beam tech. may continue to use them. ● New applicants must use fan beam tech. ● Provide evidence of Preventative Maintenance performed by the manufacturer of the DEXA equip. at the intervals suggested by the manufacturer	● DEXA only ● Devices > 6 yrs. must be inspected and recalibrated annually by a physicist with report submitted to CCN	● QC Program ● Axial DEXA system or Quantitative CT ● No Requirements Staffing: ● Limited to hospitals, radiologist, rheumatologists, endocrinologists, OBGYNs and PCPs ● At least one physician and tech from each practice location with ISCD by Nov. 1, 2006 ● 10 day TAT ● No Requirements	● QC Program ● Axial DEXA or Quantitative CT Staffing: ● 0 day TAT ● Performed by hospitals, or by radiologists, endocrinologists, rheumatologists, OB/GYNS, and orthopedists. ● At least one physician and tech with ISCD accreditation.		Not Listed

	CareCore National (For New Site or Modality Applications)	CareCore National (Standard for Continued Participation) *These standards will become effective 7/1/07	Anthem (Connecticut and Colorado)	Highmark (Pennsylvania)	HealthHelp (Radiadd On line assessment of an imaging provider's or physician practice's equipment, policies and personnel	BCBS IL, MA, RI & OK
Plain Films			●QC Program ●Automatic processor Staffing ●Tech licensed by state or other state recognized entity, or certified by the ARRT, ACRRT, ASPMA ●10 day TAT Other: ●Board certified radiologist to over-read films within 5 business days	●QC Program ●Automatic processor Staffing: ●10 day TAT ●State licensed or ARRT certified tech		Not Listed
Other Notes		●Accredited equipment that doesn't meet age requirements, may be used for back-up or overflow purposes	●Owned by the provider or leased by the provider on a full-time basis ●Subject to unannounced site inspections ●Restrictions/Review on Imaging at Multi-Specialty Group Practices	●Will reimburse providers for services on imaging equipment (i) owned by the provider or (ii) leased by the provider on a full-time basis.	HealthHelp also offers... ●RadConsult® An evidence -based alternative to pre-certification that enhances physician's ability to order appropriate diagnostic imaging by giving them the latest information ●RadCare® A traditional pre-certification program with an educational edge ●CodeRight® A claims-review program for radiology claims, ensures correct provider billing and correct payment ●RadScope® Helps prevent radiation-quality patient care by helping them purchase imaging services from physicians who have been trained in an accredited medical school for specific imaging procedures ●RadCase® is an on-line ACCME-accredited education program designed to improve radiology among non-radiology specialists	